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Coding&Billing Quarterly

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In This Issue

Letter from the Editor

September marks the launch of the CMS Open Payments data system, a website that publicly reports industry payments and other transfers of value to physicians. The Open Payment program, in the words of CMS, is designed to "…encourage transparency about these financial ties, provide information on the nature and extent of the relationships, helps to identify relationships that can both lead to the development of beneficial new technologies and wasteful healthcare spending and helps to prevent inappropriate influence on research, education and clinical decision making."

Many physician organizations, including the ATS, have expressed concern with the accuracy of the data provided by industry and the proper context for it to be interpreted by the public.

On a whim, I decided to look up the information available on the members of the ATS Clinical Practice Committee, many of who contribute to writing this newsletter, and here is what I found. Of the 15 committee members – 9 have no publicly reported payments data. Of the remaining 6 members, 5 report in kind food and beverage related industry payments. Of the 5 in kind food and beverage payments, it looks like 2 members participated in 1 industry sponsored lunch event, and the remaining 3 went to as many as 4 industry sponsored lunch events – the largest amount indicated $100 in industry supplied food over several entries. The final remaining committee member had just under $5,000.00.

So what do these data tell the public? Here are my quick takeaways. First, our health care system is spending a lot of time and energy tracking token payments for industry sponsored lunches. The time and energy needed to track, report and publish these small amounts from industry are resources that could be better spent elsewhere in our health care system. Second, the public is not yet being well served by the database. Publicly reporting that a physician received $15, $30 or even $100 in industry sponsored lunches doesn't provide much useful information. Third, the ATS Clinical Practice Committee is pretty free of industry conflicts. Yes, one member has what could reasonably be considered a large amount of industry funds, but those funds were reported to the ATS during the COI disclosure process, and this member's expertise in an emerging device driven field of pulmonary medicine is a valuable contribution to the committee.

Readers should be mindful that over $1 billion in industry payments are not yet publicly reported. Of that $1 billion, a majority is related to research payments for drugs and devices that are not yet on the market. To prevent potential disclosure of business development secrets, the law that created the open payment system, required such research development payments be reported, but not publicly released until 5 years after the payment was made. The remainder of the $1 billion in unreported funds is from disputes between physicians and industry about reported payments.

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While reasonable people can disagree about the utility of the Open Payments reporting system, it's pretty clear this requirement will be around for a while. If you are a physician who receives industry payments – even in the form an industry lunch – you should first know what the public reporting system says about you. Payment information can be found at: http://www.cms.gov/openpayments/index.html (*You will need to create an account to access the information.*)

Second, you should be prepared to dispute any inaccurately reported industry payments. The above website provides information on how to dispute industry reported data. Third, be prepared to talk with your patients about the industry payments you receive.

Switching topics, this edition of the ATS Coding and Billing Quarterly continues our discussion on ICD-10 coding, this time specificly regarding critical care. This edition also summarizes ATS recent comments on the CMS proposed 2015 Medicare Physician Fee Schedule and proposed 2015 Hospital Outpatient Prospective Payment.

Sincerely,

Alan L. Plummer, MD
Editor

ATS COMMENTS ON PROPOSED CMS RULES FOR 2015

This summer, the ATS submitted comments on two important rules proposed by CMS that will impact Medicare policy and payments for 2015. The first comments dealt with CMS's proposals for the Medicare Physician Fee Schedule for 2015 which covers a wide range of regulatory and payment polices that impact Medicare Part B providers. The ATS comments covered many of the issues that impact ATS members. Below is a brief summary of the ATS comments.

Sustainable Growth Rate Formula – the ATS continues to be frustrated with the inability of Congress and the Administration to develop a permanent solution to the SGR crisis. While the ATS noted efforts the Administration and Congress have taken to implement short-term fixes, the persistent lack of an enduring fix to the SGR formula continues to erode provider and beneficiary confidence in the Medicare program.

Sleep Practice Expense – The ATS supported a CMS proposal to add the cost of capnography equipment to pediatric sleep testing codes. While the ATS supported this particular practice expense change, we noted CMS is presenting data on proposed practice expense changes in a way that is not transparent.This makes analysis and response to proposed CMS changes problematic. The ATS comments urged CMS to develop alternative ways to present practice expense data that are more transparent.

OPPS and ASC Rates for Developing PE RVUS – the ATS is pleased that CMS is abandoning its proposal to use OPPS and ASC values to establish PE values in the Medicare Physician Fee Schedule. As outlined in our comments on the 2014 proposed Medicare Physician Fee Scheduled rule, we believe such a policy is unjustified.

Modifier to Track Hospital Owned Physician Practice Billing – While ATS supports the collection of this data in order to ensure accurate and appropriate payment rates across different settings, we believe there are less burdensome methods that would capture the same information. For example, CMS can readily obtain this information through place of service indicators or on facility addresses instead of creating a new HCPCS modifier. Should CMS require a mechanism on the claim, an alternative to a modifier would be to make a check box on the claim for purchased services.

Potentially Misvalued Codes CPT 94010 – the ATS agrees that **94010** meets CMS criteria for a potentially misvalued code and ATS has submitted a workplan to lead the effort to resurvey this pulmonary testing code.

Chronic Care Management and Chronic Disease Management – The ATS notes with great interest a CMS proposal on chronic care management and chronic disease management. In brief, we believe the proposal fails to recognize the important differences between chronic care management and chronic disease management. Chronic

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disease management refers to treating patients with chronic diseases largely by adhering to established treatment guidelines. Chronic care management refers to patients who cannot be treated using standardized guidelines, typically because their clinical condition is atypically complex.

Changes to Sunshine Reporting Provisions – The ATS is extremely concerned that CMS is proposing to eliminate the Sunshine reporting exemption for ACCME accredited educational events. We recognize that CMS feels it is inappropriate for its regulatory policy to specifically articulate which accrediting agencies earn the exemption (and by exclusion, which don't). While we understand the reluctance of CMS to review every accrediting body's request for inclusion in the reporting exemptions, we disagree with the CMS position that eliminating the ACCME reporting exemption will have minimal impact on educational product providers because they can still meet the third party transfer payment reporting exemption.

The ATS supports the proposed revision to the third party transfer reporting exemption developed by the American Medical Association. This proposed revision is supported by several physician sister societies.

Physician Quality Measures – ATS notes that CMS is proposing to retire two COPD-related physician quality reporting measures (COPD: Spirometry Evaluation and COPD Inhaled Bronchodilator Therapy) and the COPD Measure Group due to lack of a measure sponsor. The ATS is pleased to report it has reached an agreement with AMA-Physician Consortium for Performance Improvement and will assume sponsorship of the two COPD individual measures. Our sponsorship and upkeep of these measures should allow CMS to continue to use these two individual measures and continue the COPD Measures Group for 2015 and beyond.

The second rule the ATS reviewed and commented on covers the Medicare proposed rule for the hospital outpatient prospective payment system. The ATS comments focused on two issues;

G0239 Proposed APC Reassignment – the ATS opposed the CMS proposal to reassign **G0239** (other respiratory procedures, group) from APC 0077 to APC 0450. This proposal was made without discussion, making it challenging to respond to this policy proposal.

To more accurately capture hospital charge data associated with **G0424** and **G0237**, **G0238**, and **G0239**, ATS recommends that CMS establish revenue codes to use when reporting these services. We further recommend CMS not make any APC changes to **G0239** until data from the revenue code reporting can be collected and analyzed.

APC Adjustments – the ATS noted with concern that in this rule, CMS has proposed a significant number of APC changes to codes that significantly impacts the reimbursement for the underlying code. In most cases, the APC changes are done without explicit notice and provide no background discussion for why CMS is proposing the change. CMS's "stealth" APC changes leave the provider community with little to no insight on why CMS's is proposing the change and how to respond to the proposed APC change constructively .

The ATS strongly recommends that for future proposed rules, when APC changes result in a change of 10% or more in the reimbursement for the code, that CMS explicitly recognize the APC change and provide some background information on why CMS is proposing the change. We believe making explicit recognition of the APC change and providing the background rationale will allow the provider community to respond with thoughtful and constructive comments.

The final rule for both the 2015 Medicare Physician Fee Schedule and the Medicare Hospital Prospective Payment System is expected in November 2014. The next issue of the *ATS Coding and Billing Quarterly* will provide an analysis of the final rules.

ICD-10-CM: CRITICAL CARE

In the July 2014 issue of CBQ, we reviewed the coding for obstructive lung diseases. In this issue we will tackle coding for critical care. The ICD-9 Clinical Modification (CM) and ICD-10-CM codes for respiratory failure codes are listed in Table 1. Some of the non-respiratory failure critical care codes are listed in Table 2. As we described in prior editions, ICD-10-CM requires more detailed documentation to avoid non-payment. In particular, we need to document: acute vs subacute vs chronic; left vs right; etiology; severity; and associated organ dysfunction. Each permutation of these specifics carries a unique code in ICD-10-CM. Another theme of ICD-10-CM is to document when problems are occurring in the setting of pregnancy or the perinatal period. Pulmonary, cardiac and other organ critical care problems among obstetric patients have unique codes. ICD-10-CM places emphasis on using additional codes to identify tobacco's role among relevant critical care diseases (Table 2).

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With ICD-10-CM, coding for respiratory failure becomes much more complex. The number of codes available more than doubles (Table 1). A new code, **J80**, Acute Respiratory Distress Syndrome, is available for use. Two new codes for acute (**J95.821**) and acute and chronic (**J95.822**) post-procedural respiratory failure are in place to use. The familiar diagnoses, acute, chronic or acute and chronic respiratory failure will require documentation of hypoxia and/or hypercapnia. A new category of codes for unspecified respiratory failure have been added, again with codes requiring documentation of hypoxia and/or hypercapnia.

Acute pulmonary insufficiency in the post-operative setting needs to be defined in terms of post thoracic surgery (**J95.1**) and post non-thoracic surgery (**J95.2**), which are new codes (Table 1). Acute respiratory failure following procedures is described as acute post-procedural respiratory failure (**J96.821**) (Table 1).

When describing heart failure with ICD-10-CM, there will be a need to add the cause of heart failure in terms of systolic, diastolic, and combined systolic/diastolic, or unspecified, similar to the coding in ICD-9-CM (Table 2). Also there will be a need to code specific episodes of heart failure occurring in settings such as following surgery (**I97.13x**), due to hypertension (**I11.0**), or due to hypertension and chronic kidney disease (**I13.0**), among others.

When diagnosing cardiac arrest, it will be important to describe the cause as unspecified (**I46.9**), due to a cardiac condition (**I46.2**), or due to "other" conditions (**I46.8**), coding the underlying condition first.

The presence (**I26.09**) or absence (**I26.99**) of acute cor pulmonale should be stated when diagnosing pulmonary embolism, which will be new codes to use.

Sepsis in ICD-10-CM can be coded as sepsis, unspecified organism (**A419**), but a better choice would be to document the organism or at least the family of the organism. When coding for sepsis, document if the specific episode follows a procedure (post-procedural sepsis **T81.4**). Severe sepsis with septic shock is **R65.21**. When coding septic shock, again document specific episodes following procedures (**T81.4**), episodes among obstetric patients, and identify specific acute organ dysfunction. As always, never use urosepsis. There is no code for urosepsis.

In ICD-9-CM, we could describe **430** as subarachnoid hemorrhage and **432.9** as unspecified intracranial hemorrhage. In ICD-10-CM, we will need to document

Table 1: Pulmonary Critical Care Codes

ICD-9-CM	
518.81	Acute respiratory failure
518.82	Other pulmonary insufficiency, NEC (ARDS)
518.83	Chronic respiratory failure
518.84	Acute and chronic respiratory failure
518.51	Acute respiratory failure following trauma and surgery
518.52	Other pulmonary insufficiency NEC, following trauma and surgery
518.53	Acute and chronic respiratory failure following trauma and surgery
ICD-10-CM	
J80	Acute respiratory distress syndrome
J96.00	Acute respiratory failure, unspecified whether with hypoxia/hypercapnia
J96.01	Acute respiratory failure with hypoxia
J96.02	Acute respiratory failure with hypercapnia
J96.10	Chronic respiratory failure, unspecified whether with hypoxia/hypercapnia
J96.11	Chronic respiratory failure with hypoxia
J96.12	Chronic respiratory failure with hypercapnia
J96.20	Acute and chronic respiratory failure, unspec. whether with hypoxia/hypercapnia
J96.21	Acute and chronic respiratory failure with hypoxia
J96.22	Acute and chronic respiratory failure with hypercapnia
J96.90	Respiratory failure, unspecified, unspec. whether with hypoxia/hypercapnia
J96.91	Respiratory failure, unspecified with hypoxia
J96.92	Respiratory failure, unspecified with hypercapnia
J95.1	Acute pulmonary insufficiency following thoracic surgery
J95.2	Acute pulmonary insufficiency following non-thoracic surgery
J95.3	Chronic pulmonary insufficiency following surgery
J95.821	Acute post-procedural respiratory failure
J95.822	Acute and chronic post-procedural respiratory failure

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Table 2: Non-Pulmonary Critical Care Codes

ICD-9-CM	
428.0	Congestive heart failure, unspecified
428.20	Unspecified systolic heart failure
428.21	Acute systolic heart failure
428.22	Chronic systolic heart failure
428.23	Acute on chronic systolic heart failure
428.30	Unspecified diastolic heart failure
428.31	Acute diastolic heart failure
428.32	Chronic diastolic heart failure
428.33	Acute on chronic diastolic heart failure
428.40	Unspecified combined systolic and diastolic heart failure
428.41	Acute combined systolic and diastolic heart failure
428.42	Chronic combined systolic and diastolic heart failure
428.43	Acute on chronic combined systolic and diastolic heart failure
427.5	Cardiac arrest
415.19	Other pulmonary embolism and infarction
785.52	Septic shock
995.90	Systemic inflammatory response syndrome, unspecified
995.91	Sepsis
995.92	Severe sepsis
ICD-10-CM	
I50.20	Unspecified systolic (congestive) heart failure
I50.21	Acute systolic (congestive) heart failure
I50.22	Chronic systolic (congestive) heart failure
I50.23	Acute on chronic systolic (congestive) heart failure
I50.23	Acute on chronic systolic (congestive) heart failure
I50.30	Unspecified diastolic (congestive) heart failure
I50.31	Acute diastolic (congestive) heart failure
I50.32	Chronic diastolic (congestive) heart failure
I50.33	Acute on chronic diastolic (congestive) heart failure
I50.40	Unspecified combined systolic and diastolic (congestive) heart failure
I50.41	Acute combined systolic and diastolic (congestive) heart failure
I50.42	Chronic combined systolic and diastolic (congestive) heart failure
I50.43	Acute on chronic systolic and diastolic (congestive) heart failure
I50.9	Unspecified heart failure
I26.09	Other pulmonary embolism with acute cor pulmonale
I26.99	Other pulmonary embolism without acute cor pulmonale
I46.2	Cardiac arrest due to underlying cardiac condition
I46.8	Cardiac arrest due to other underlying condition
I46.9	Cardiac arrest, cause unspecified
A41.0-89	Sepsis due to specific organisms or class of organisms
A41.9	Sepsis, unspecified organism
R65.10	Systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction
R65.20	Severe sepsis without septic shock
R65.21	Severe sepsis with septic shock
Additionally, code for tobacco use when related to the critical care code:	
Z72.0	Tobacco use
Z87.891	Personal history of nicotine dependence
F17.2x	Nicotine dependence

whether the cause is traumatic (**I162.9**) or nontraumatic (**I60.9**). As always, we should describe location, laterality, causes (alcohol and/or tobacco).

In general the documentation requirements for physicians will increase when ICD-10-CM is instituted. Among our ICU patients, these requirements will revolve around acuity, location, cause, severity, and effects on other organs. With ICD-10-CM paying specific attention to the contribution of tobacco and critical illness among all patients also will be necessary (Table 2).

Resource: www.goto10.org/

www.ama-assn.org/go/ICD-10

Q&A

51 Modifier

Q. I have an Inpatient claim for CPT codes **31628** and **31624** which were originally billed with no modifiers with a diagnosis of **486**. The payer originally paid the entire claim. They then retracted the payment for CPT code **31628**. I then billed the claim adding a 51 modifier on CPT code **31624**. The payer then paid both lines of the claim.

A. As a general rule, the use of modifier 51 is not required when billing for multiple bronchoscopic procedures. However, this may be required by your local Medicare contractor or other third-party payer.

25- Modifier

Q. A patient in the ICU has a central line placed at 8 pm by the nighttime intensivist, Dr. B. The "daytime" intensivist, Dr. A in the same group practice saw and billed the Critical Care charge for the day (**99291**) at 11 AM. Does Dr. A have to add the -25 modifier to the 99291?

A. No, the -25 modifier is appended to the E/M service if a significant, separately identifiable service is also performed by the same physician (not someone in the same group), on the same calendar day. Documentation of the E/M must go beyond the usual pre and postoperative care association with the procedure. In this example the Critical Care (**99291**) service occurred in the morning and the procedure was performed by a different physician later the same day. If Dr. B only preforms the central line placement (**36556**), no -25 modifier is necessary. However, if Dr. A placed the central line, he/ she would have coded **99291-25, 36556**.

Shared E&M Coding

Q. I have a PA in my practice and we use "shared medical appointments" in the office. We saw a patient with COPD together who is a smoker. My PA counseled the patient on smoking cessation for 6 minutes and documented the discussion including the time, the options for cessation and the comorbidities/ pulmonary diagnoses. Do we submit the charge for smoking cessation counseling, intermediate >3-10 minutes **99406** using my name or my PA's?

A. The ability to "share'" a service refers only to E&M codes (excluding certain ones like critical care). This is because they are described as being billed "per day" by the same provider in the same specialty of the same group practice. Since smoking cessation counseling is a separate code that describes a separate service, then "shared" service rules do not apply. In this situation, your PA who did the counseling, should document the service and then bill it. As all services with nonphysican providers (NPPs), they will be reimbursed at 85% of the physician rate.